Commonwealth of Massachusetts
Group Insurance Commission

Your Benefits Connection

Dependent Age 19 or Over Application for Continued Coverage *Instructions*

Your dependent's insurance coverage status changes on the last date of the month in which he/she turns age 19. **YOU MUST COMPLETE THE ATTACHED FORM IN ORDER TO CONTINUE YOUR UNMARRIED DEPENDENT'S (AGE 19 OR OVER) HEALTH COVERAGE TAX-FREE IF YOU ARE ENTITLED TO IT.** If you do not complete the enclosed application, your dependent will be defaulted to a coverage status that will result in tax consequences to you, the insured. Complete and return in full the *Dependent Age 19 or Over Application* on pages 2 and 3 of this document prior to the dependent's 19th birthday. Please keep in mind the following dependent considerations:

- Only full-time students at accredited schools are eligible for student coverage.
- Dependents who at age 19 are mentally or physically incapable of earning their own living may be eligible for handicapped dependent coverage. Please contact the GIC for a *GIC Handicapped Dependent* application to apply for this coverage.
- If your dependent age 19 or over is not a full-time student or a handicapped dependent, he or she may be eligible for continued coverage under the Massachusetts Health Care Reform Act. IRS dependents are eligible for coverage up to age 26 or two years after losing dependent status according to Internal Revenue Code rules, whichever occurs first.
- The insured must have family plan coverage.
- Married dependents are not eligible for GIC coverage.

The GIC will determine coverage eligibility and effective dates. Once approved, your Plan will contact you periodically to re-verify your dependent's eligibility status. **IF YOU DO NOT RESPOND TO THESE REQUESTS FOR RE-VERIFICATION, YOUR DEPENDENT'S COVERAGE WILL BE TERMINATED.**

You must notify the GIC when your dependent:

- Is no longer a full-time student
- Withdraws from school
- Is on a medical leave of absence from school or the medical leave of absence ends
- Graduates
- Ceases to be an IRS dependent

At that time, you can apply for continued coverage by completing and returning both pages of the attached form to the GIC.

- For clarification of Internal Revenue Service (IRS) rules for dependents, contact the IRS or a tax professional.
- We can only accept original applications, not photocopies or faxed transmittals.
- Keep a copy of this application for your records.

Questions?
617.727.2310
www.mass.gov/gic

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DEPENDENT AGE 19 AND OVER APPLICATION FOR COVERAGE

1. ALL APPLICANTS MUST COMPLETE THIS SECTION

PLEASE PRINT AND ANSWER ALL QUESTIONS, sign the form after reviewing the terms and conditions, sending the completed form according to the mailing instructions in section 6. Be sure to refer to important information on page one of this application.

Please indicate the reason for your application for dependent age '19 and over' continued coverage:

___ Full-time student (complete section 2)

___ Handicapped dependent (complete section 3 and apply for coverage with a GIC *Handicapped Dependent Application*.)

___ IRS Dependent Age 19-26 (complete section 4)

___ Non-IRS Dependent Age 19-26 (complete section 5)

Name of Insured_____ Insured's Social Security #_____

Address_____ Telephone Number (_____)_____

_____

Place of Employment_____

Name of Dependent _____ Dependent's Social Security #_____/_____/_____

Relationship to Insured_____ Dependent's Date of Birth ___/___/___

2. FULL-TIME STUDENT COVERAGE

Name of Accredited Educational Institution Student is Attending_____

Address of School_____

City, State, Zip_____

The above student has been accepted or is currently enrolled full-time in an educational institution.

Date Admitted:_____ Expected date of graduation: Month_____Year_____

a. Has he/she been considered full-time since admission? ___ yes ____no
If no, other than for a medical leave, when was he/she not considered full-time? _____

Part-time students are not eligible for student coverage. *Complete section 4 or 5.*

b. Is the student on a medical leave of absence? Yes_____ No_____ If yes, leave approved From____ To_____

I understand that I must notify the GIC when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, the medical leave of absence ends, or my dependent graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form. Under the pains and penalties of perjury, I attest that all statements on this form are true. I further understand that if I misrepresent or provide false or incomplete information, my GIC coverage may be terminated (including retroactively), in addition to other legal remedies, at the discretion of the GIC, .

Signature of Insured_____ Date_____

3. HANDICAPPED DEPENDENT COVERAGE

My dependent is disabled and has been prior to age 19. I will apply for handicapped dependent coverage using the GIC's *Handicapped Dependent Coverage* application. I have read the important information section on page one of this form.

Signature of Insured_____ Date_____

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DEPENDENT AGE 19 AND OVER APPLICATION FOR COVERAGE *(continued)*

4. IRS DEPENDENT AGE 19-26 COVERAGE

My dependent listed on page 2 is a dependent under IRS rules. I have or will claim him or her as an exemption on my federal tax forms filed with the Internal Revenue Service (IRS) in the following calendar year:

_____
Calendar Year

I have read the important information section on page one of this form. Under the pains and penalties of perjury, I attest that all statements on this form are true. I further understand that if I misrepresent or provide false or incomplete information, my GIC coverage may be terminated (including retroactively), in addition to other legal remedies, at the discretion of the GIC.

Signature of Insured_____ Date_____

5. NON-IRS DEPENDENT AGE 19-26 COVERAGE

My dependent listed on page 2 is not a dependent under IRS rules. I have or will stop claiming him or her as an exemption on my federal tax forms filed with the Internal Revenue Service (IRS) in the following calendar year:

_____
Calendar Year

I have read the important information section on page one of this form. Under the pains and penalties of perjury, I attest that all statements on this form are true. I further understand that if I misrepresent or provide false or incomplete information, my GIC coverage may be terminated (including retroactively), in addition to other legal remedies, at the discretion of the GIC.

Signature of Insured_____ Date_____

6. MAILING INSTRUCTIONS

INITIAL ENROLLMENT, GIC DENTAL/VISION ONLY COVERAGE, AND STATUS CHANGES - SEND TO THE GIC

GIC, Dependent Age 19 and Over Unit, P.O. Box 8747, Boston, MA 02114-8747

RECERTIFICATION - SEND TO YOUR HEALTH PLAN

Commonwealth Indemnity Plans: UniCare, Commonwealth Service Center, P.O. Box 9016, Andover, MA 01810-0916

Fallon Community Health Plan: FCHP, One Chestnut Place, Worcester, MA 01608

Harvard Pilgrim Health Care: HPHC, Account Services GIC Coordinator, P.O. Box 9185, Quincy, MA 02269

Health New England: HNE, One Monarch Place, Springfield, MA 01104

Tufts Health Plan: Tufts Health Plan, Commonwealth of MA Enrollment, 705 Mount Auburn Street, P.O. Box 9186, Watertown, MA 02471-9186

Neighborhood Health Plan: NHP, 253 Summer Street, Boston, MA 02210

7. FOR GIC AND PLAN USE ONLY

Approved_____ Effective Date____/____/____ Expiration Date _____/____/_____

Denied_____ Reason_____

Reviewed by _____ Date____/____/____